

TENTH PACIFIC HEALTH MINISTERS MEETING

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**TOWARDS HEALTHY ISLANDS:
PACIFIC NONCOMMUNICABLE DISEASE RESPONSE**

In 2011, Pacific island ministers of health and Pacific Islands Forum leaders declared a health and development crisis in the Pacific island countries and areas (PICs) due to the high burden of noncommunicable diseases (NCDs). The crisis is a major barrier to achieving the Healthy Islands vision for the Pacific.

As a result of the 2012 Pacific NCD Forum, PICs developed crisis response packages (CRPs) which are action plans aligned with national NCD strategies and guided by local data and WHO's "best-buy" interventions. Most countries prioritized tobacco control efforts, salt reduction strategies and the provision of quality NCD services at the primary health-care level in their CRPs.

Multisectoral action to address the NCD crisis was further enhanced through meetings and the initiation of joint programming with the sports and trade sectors. Surveillance has improved through strengthening of civil registration and vital statistics (CRVS) systems, including those for the certification of cause of death. In addition, surveys for NCD surveillance using the WHO STEPwise Approach to Surveillance of Risk Factors for NCDs (STEPS) were carried out in several countries, with a few countries repeating the survey to monitor trends over time. Several countries have implemented the WHO Package of Essential NCD Interventions, known as PEN, which incorporates both clinical and community interventions to strengthen health system capacity for NCD service delivery.

Although there has been considerable progress, scaled-up action is required to address challenges such as lack of effective in-country multisectoral institutional mechanisms for the development and implementation of NCD interventions, as well as limited institutional capacity and support for sustaining improvements with surveillance and monitoring.

Ministers of health are invited to discuss possible approaches for scaling up actions to address the NCD crisis and consider increased investment in NCD prevention and control. Such approaches may include setting a collective goal to achieve a tobacco free Pacific, agreeing to and promoting a set of salt reduction targets for the Pacific, investing in national implementation of PEN in an effort to strengthen health systems, enhancing national surveillance systems through mechanisms such as the Pacific Monitoring Alliance for NCD Action, and continuing to advocate for the collaboration of other sectors in multisectoral action to mitigate the NCD crisis.

1. BACKGROUND

Noncommunicable diseases (NCDs), namely cardiovascular disease, diabetes mellitus, chronic respiratory disease and cancer, are responsible for approximately 75% of deaths in the Pacific island countries and areas (PICs) and most premature deaths. This heavy burden of mortality reflects the alarmingly high prevalence of the risk factors for NCDs, in particular staggering rates of tobacco use, physical inactivity, unhealthy diets and the harmful use of alcohol. Subsequently, the Pacific island region and its health systems are straining to cope with elevated rates of blood pressure, blood sugar, cholesterol and obesity, including childhood obesity.

Although not measured systematically, countries report a high prevalence of disabilities due to NCDs, with one country reporting one in 10 people with diabetes having had amputations. Many of these disabilities and subsequent deaths from NCDs, especially those which occur before the age of 60 years, carry health and social costs that deny individuals, families, communities and nations the ability to attain their aspirations and realize their full potential.

NCDs have become one of the major barriers to achieving the Healthy Islands vision of the Pacific health leaders that was articulated in 1995 in the Yanuca Declaration.¹ Within and between countries, inequities in the impact of NCDs are evident, with the poorest who are most affected yet least likely to receive the primary prevention or curative interventions from health services inadequately equipped to manage NCDs.

Recognizing the depth of the problem, in June 2011, Pacific health ministers issued the Honiara Communiqué, which urged Pacific leaders to declare an NCD-related health and development crisis in the Pacific. In September 2011, representatives at the 42nd meeting of the Pacific Islands Forum Leaders declared an NCD crisis in the Pacific. One week later in New York world leaders issued the Political Declaration of the High-level Meeting of the

¹ Healthy Islands are places where children are nurtured in body and mind, people work and age with dignity, environments invite learning and leisure, ecological balance is a source of pride and the ocean that sustains us is protected.

General Assembly on the Prevention and Control of Non-communicable Diseases.² Several PICs also have issued national declarations of health crises and emergencies due to NCDs.³

As a follow-up to the United Nations political declaration, nine voluntary global targets for NCDs have been established to guide the international response to the crisis (Annex 1). PICs are committed to reaching the overarching target of a 25% relative reduction in deaths of people between the ages of 30 and 70 years from NCDs by 2025. To achieve the targets and tackle the crisis effectively, accelerated and intensified action needs to be taken immediately and sustained throughout the Pacific.

2. ACHIEVEMENTS AND PROGRESS

The 2-1-22 Pacific NCD Programme⁴, supported by the Australian Agency for International Development (AusAID) and the New Zealand Aid Programme, assisted PICs in developing national NCD strategies. There has been a general increase in the commitment of national resources over the last few years in an effort to move away from dependence on external funding. This increase in investment by governments for NCD prevention and control demonstrates political will and leadership in the Pacific.

In response to the declaration of an NCD crisis by the Pacific Islands Forum leaders, the Pacific community has been mobilized to address the crisis as was evidenced by actions at the Fourth Pacific NCD Forum in June 2012. Thirteen PICs have now developed Crisis Response Packages (CRPs) within the context of their respective NCD strategies. The CRPs prioritized high-impact strategies and activities that are cost effective, practical and give the best value for the limited resources available. These strategies and activities were drawn from the very cost-effective interventions ('best buys') for prevention and control of NCD for low- and middle-income countries, which were developed with support from the World Economic Forum. (Annex 2). The CRPs have since become a valuable tool for translating national NCD strategies into action plans.

² United Nations A/RES/66/2. Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases.

http://www.who.int/nmh/events/un_ncd_summit2011/political_declaration_en.pdf

³ American Samoa, the Federated States of Micronesia (Chuuk, Kosrae), Palau and the Marshall Islands.

⁴ The 2-1-22 program was named for two organisations and one team serving 22 countries and areas in the Pacific. http://www.spc.int/hpl/index.php?option=com_content&task=view&id=25&Itemid=49

Under their respective CRPs, most countries have prioritized, in addition to current efforts, the following strategies and interventions:

- A. Multisectoral response
 - a. Tobacco control
 - b. Salt reduction
- B. Health system response
 - a. Package of Essential NCD Interventions, or PEN
- C. Surveillance
 - a. Risk factors: NCD STEPS surveys
 - b. Mortality: Civil registration and vital statistics (CRVS), with cause-specific mortality

These priorities have become the focus of attention and of support for implementation, with some notable progress.

Multisectoral response

Facilitation of multisectoral engagement at the regional level continued with two significant meetings—*Healthy Islands through Sports*, and *Trade and NCDs*—both of which fostered partnerships for joint in-country work among relevant sectors. The meetings were jointly organized by the Secretariat of the Pacific Community (SPC) and WHO, together with the Australian Sports Commission, the United Nations Development Programme and the Pacific Research Centre for the Prevention of Obesity and Non-communicable Diseases (C-POND). Follow-up work in countries has been carried out with joint programmes initiated both for sports (a sports outreach programme) and trade (establishment of national trade committees). In addition, collaboration on the implementation of the *Framework for Action on Food Security in the Pacific* has progressed and specific country projects have been identified and supported in the Federated States of Micronesia, Fiji, Kiribati, Samoa, Tonga, Tuvalu, and Vanuatu.

The majority of PICs have tobacco laws and have shown some progress in meeting the requirements of the WHO Framework Convention on Tobacco Control (WHO FCTC). In April 2013, Kiribati became the most recent country to pass tobacco control legislation. Tobacco tax increases have been pursued, and a training workshop was conducted for health

and finance officials and customs officers from several PICs. Four PICs have raised taxes on tobacco products in their 2013 budgets.⁵ A few other PICs are poised to do so in their next budget cycles. The Blue Ribbon Campaign (BRC) is focused on preventing exposure to second-hand smoke through the promotion and recognition of smoke-free environments. The BRC is being implemented in nine PICs.⁶ Further, following the Fifth Session of the Conference of the Parties to the WHO FCTC (COP-5) in 2012, most PICs have made the decision to ratify the *Protocol to Eliminate Illicit Trade in Tobacco Products* and have been supported in these efforts. Work on alcohol harm reduction has been mainly focused on enacting legislation that incorporates alcohol harm reduction measures into existing related legislation, such as liquor laws or public health laws.

For diet and physical activity, there has been a major focus on salt reduction, in addition to the current promotion of fruits and vegetables, and specific national plans incorporating salt reduction have been developed and initiated in 13 PICs with varying levels of implementation.⁷ These countries have completed shop surveys to ascertain salt levels in common food products, providing valuable information on the nutritional content of the populations' diet. Several countries have conducted training on risk-based food inspection for food inspectors. There has been increased engagement with relevant sectors, including the private sector, on food control. As a result, multiple milestones have been reached including the introduction of food labelling, targets and standards for certain nutrients in food, taxation of sugar-sweetened beverages, and the adoption of regulations on the marketing of food and non-alcoholic beverages to children in some PICs.

Health System Response

The Package of Essential NCD Interventions, or PEN, for primary health care has been embraced by health practitioners and communities across the Pacific as an essential tool to strengthen health systems for the prevention and management of NCDs. PEN primarily involves cardiovascular disease risk assessments and predictions based on six key variables (age, gender, diabetes, tobacco use, blood pressure and cholesterol), with appropriate counselling and pharmaceutical management of the risk at the individual level, linked with lifestyle interventions. These interventions for those at high risk are intended to complement

⁵ Cook Islands, Fiji, Papua New Guinea, Tonga

⁶ Cook Islands, the Federated States of Micronesia, Fiji, Kiribati, Palau, Samoa, Solomon Islands, Tonga, Vanuatu

⁷ Cook Islands, the Federated States of Micronesia, Fiji, Guam, Kiribati, the Marshall Islands, Nauru, Palau, Samoa, Solomon Islands, Tonga, Tuvalu, Vanuatu

population-based interventions for reducing exposure to risk factors. Ten PICs⁸ have begun implementing PEN, with five already moving from the feasibility phase to the national roll-out phase. There are plans to initiate PEN in five additional countries in the latter part of 2013. Seventy-two health facilities in the countries involved participated in the initial feasibility phase, mainly primary care centres of varying sizes, with a population coverage of 10%–66% in each of the PICs. Of those screened through PEN implementation, 20%–30% were assessed to have greater or equal to 20% risk for having a fatal or non-fatal cardiovascular event within the next 10 years. This large proportion of individuals found to be at such high risk adds value to current NCD services being carried out in each country.

Surveillance

Mortality surveillance has been strengthened through coordination by the University of Queensland Health Information Systems Knowledge Hub (HIS Hub) and SPC to support PICs in undertaking an assessment of their civil registration and vital statistics (CRVS) systems and developing and implementing national improvement plans. Together with WHO, the HIS Hub also provides support for improvement of cause-of-death certification by medical personnel. This key area of focus should result in improved vital registration processes and improved quality of death certification practices of doctors, leading to improved quality of mortality data needed for NCD monitoring.

For risk factor surveillance in adults, the NCD STEPS and Behavioural Risk Factor Surveys (BRFS) are the main instruments, along with demographic and health surveys. In 2013, four countries will publish their initial NCD STEPS reports (the Federated States of Micronesia, Niue, Papua New Guinea and Vanuatu), and at least three (Cook Islands, Fiji and Samoa) will publish the results of the second round of STEPS surveys, and one country (Tonga) completed data collection of their second round STEPS survey. Modules to measure sodium or salt intake are being incorporated into the NCD STEPS survey instruments, and the data collected are now able to provide population cardiovascular disease risk profiles using WHO/International Society of Hypertension (ISH) risk prediction charts. In Samoa, a mental health module has been added to the STEPS survey. Increased capacity for NCD STEPS surveys is available through the training of 15 technical experts from the Pacific in STEPS methodology. They are available to assist countries with conducting STEPS surveys.

⁸ Cook Islands, the Federated States of Micronesia, Fiji, Kiribati, the Marshall Islands, Palau, Samoa, Solomon Islands, Tonga, Vanuatu

For youth and adolescents, the global school-based student health surveys (GSHS) and tobacco-specific surveys, (e.g., Global Youth Tobacco Survey (GYTS)) have been carried out in many PICs.⁹ An initial discussion on development of a platform for a network of countries, regional organizations, agencies and academic institutions to provide further coordinated regional technical support for information for action on NCDs has been carried out.

In addition to these, a study on the economic impact of NCDs was carried out by the World Bank for Samoa, Tonga and Vanuatu. The high costs of NCD treatment both for secondary and tertiary prevention were quantified and the study emphasized the need for focus on secondary prevention as well as primary prevention. From this initial work, cost implications for national PEN roll-outs have been initiated in Cook Islands and Fiji to help inform ministries of health on the design of the roll-out phase and ensure its long-term sustainability.

3. CHALLENGES AND ISSUES

With the conclusion of the 2-1-22 Pacific NCD Programme, there is a need to ensure further resources are mobilized to scale up NCD action with leadership by PICs and coordination between supporting agencies. Such an effort should establish clear stewardship over the different areas of potential action and support to countries. Although national budgets for NCDs have increased in some countries, the resources and efforts are clearly inadequate given the enormity of the NCD epidemic. There is a need for greater investment in NCD prevention and control if the response is to have a significant impact on the crisis. A sustainable funding mechanism needs to be further pursued in this context.

Implementing multisectoral action in countries remains a challenge as there is an absence of effective institutional mechanisms for implementation at the country level. Institutional mechanisms exist in some PICs that can be used as models for other countries. In Samoa, there is a parliamentary advocacy group on healthy lifestyles, and a Healthy Islands Council chaired by the Prime Minister oversees multisectoral action for NCDs. In Tonga, a national NCD committee drives multisectoral action to address diet, physical activity, tobacco use and the harmful use of alcohol. The Tonga Health Promotion Foundation

⁹ GSHS carried out in Cook Islands, Fiji, Kiribati, Nauru, Niue, Samoa, Solomon Islands, Tonga, Vanuatu ; GYTS carried out in Cook Islands, the Federated States of Micronesia, Fiji, Kiribati, Marshall Islands, New Caledonia, Palau, Samoa, Solomon Islands, Tonga, Tuvalu, and Vanuatu

technically and financially supports the subcommittees and promotes multisectoral and non-governmental organization partnerships to promote health.

An existing mechanism for capacity development involving all stakeholders in the chosen action areas would ensure a comprehensive multisectoral approach to tackling the multiple determinants of NCDs. For example, joint training in food safety of quarantine, biosecurity, customs and health inspectors could address food safety from point of entry to point of sale. Tobacco industry interference continues to be one of the main barriers to implementation of the WHO FCTC. Support for multisectoral action is necessary to prevent industry's attempts to mislead sectors and people about the negative impacts of tobacco.

Implementation of the PEN programme has shown that many health systems are ill prepared to address NCDs in accordance with the six building blocks of health systems strengthening—service delivery; financing; health workforce; medical products, vaccines and technologies; information; and leadership and governance.¹⁰ There is an urgent need for dedicated human resources with appropriate skill sets to champion and drive the necessary actions to tackle the NCD crisis. For example, in Tonga, nurses are being trained to specifically address NCDs at the primary health care level. The NCD STEPS survey in some of countries reveal that more than 50% of those defined with high blood pressure and/or diabetes had never been informed of their status, which means the proportion of undiagnosed cases is still high despite current efforts. The pharmaceutical supply chain remains a challenge as individuals with NCDs remain largely undertreated, with supplies frequently depleted. The absence of effective primary prevention drugs, for example statins, which are on the essential drug list in countries and should be available from primary health care facilities with appropriate point-of-service measurements, has to be addressed. Health information at the primary health-care level may lack the precision of measurement needed to assess effectiveness. These challenges in the health system provide opportunities to strengthen the health system building blocks through PEN implementation.

With the establishment of the nine global NCD targets, member states will want to monitor progress towards their achievement. Such a monitoring effort necessitates strengthening health information systems, including vital registration and support for surveillance. Currently, all mortality data for the Pacific are based on estimates, and risk factor data are not used to their full potential. For example, more could be done to highlight

¹⁰ http://www.who.int/healthsystems/strategy/everybodys_business.pdf

socio-demographic differences in risk factors. Furthermore, evaluation of the activities and strategies that have been implemented will be required, such as the implementation of the *Framework for Action on Food Security in the Pacific* and the implementation and impact of the PEN interventions.

4. FUTURE DIRECTIONS

Ministers of health are invited to discuss and consider the following as part of efforts to implement the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases and to continue to scale up the response to the Pacific NCD crisis.

Increase commitment and financial investment in NCD prevention and control.

Country response to the NCD crisis requires careful analysis of current health and finance data to ascertain national targets, mapping of prioritized interventions based on “best buys” within the context of national strategies, and implementation at the appropriate scale with rigorous monitoring and long-term focus through 2025. Increased investment in human and other resources to implement the response is needed and consideration of sustainable funding mechanisms, such as health promotion foundations, to support multisectoral action is critical. If NCDs are a crisis, business as usual will not suffice.

Healthy islands are tobacco free islands

With tobacco control laws in many countries aligned with the WHO FCTC and many community initiatives under way, it is time for further collective efforts. With New Zealand’s goal of a Tobacco Free New Zealand, the Pacific also can set a goal of a Tobacco Free Pacific, with a target of 10% or lower prevalence of tobacco use by 2025. This can be achieved by expedited implementation of WHO FCTC and associated community-based tobacco control and prevention programmes, with PICs accountable to one another. For most PICs, this would exceed the global target of a 30% relative reduction by 2025.

Set Pacific food standards and targets

With the ongoing promotion of physical activity, fruits and vegetables, and salt reduction, there is an urgent need to develop regional targets for maximum levels of fat, sugar and salt in food to enable countries to institute fiscal and regulatory measures for local and

imported processed foods. This should enable maximum levels of salt, among other targets, in imported foods to be mandated and mechanisms to be developed for their implementation. Similarly, it should enable taxation of empty-calorie sugar-sweetened beverages and restrictions on the sale of sugary drinks to be carried out by countries interested in such an approach.

Strengthen health systems to address NCDs

Multisectoral efforts to reduce risk factors at the population level are projected to reduce premature mortality by two thirds, but these efforts need to be coupled with universal population coverage of high-risk interventions, mainly delivered through the health system. The implementation of the PEN interventions through primary health-care services, beginning with cardiovascular disease risk assessments and management, is a good start. PICs need to consider investment in national roll-outs and evaluation of PEN interventions to all primary health-care facilities, thus increasing population access to improved NCD care and services.

Strengthen surveillance

With global targets endorsed by the Sixty-sixth World Health Assembly, there is a great need for scaling up NCD surveillance in the Pacific for both adults and youth. The implementation of repeated STEPS surveys to establish trend data for NCDs and their risk factors is one of the key actions since six of the nine global targets can be measured through STEPS and related NCD risk-factor surveys. Continued investment in improvements for CRVS systems through the use of elements of the Pacific Vital Statistics Action Plan to ensure quality data on death and cause-specific mortality is encouraged. Establishment of a regional NCD surveillance network—tentatively named the Pacific Monitoring Alliance for NCD Action (Pacific MANA)—as a platform to assist PICs in improving country-specific data to inform and direct policy action on NCDs, track progress and report against the global targets should be considered because that which gets measured, gets done. PICs need long-term planning for NCD surveillance with commensurate investment of national human and financial resources.

Comprehensive global monitoring framework, including 25 indicators, and a set of nine voluntary global targets for the prevention and control of NCDs

Framework element	Target	Indicator
Mortality and morbidity		
Premature mortality from noncommunicable disease	(1) A 25% relative reduction in risk of premature mortality from cardiovascular diseases, cancer, diabetes, or chronic respiratory diseases	(1) Unconditional probability of dying between ages of 30 and 70 from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases
Additional indicator		(2) Cancer incidence, by type of cancer, per 100 000 population
Risk factors		
Behavioural risk factors		
Harmful use of alcohol ¹	(2) At least 10% relative reduction in the harmful use of alcohol, ² as appropriate, within the national context	(3) Total (recorded and unrecorded) alcohol per capita (aged 15+ years old) consumption within a calendar year in litres of pure alcohol, as appropriate, within the national context (4) Age-standardized prevalence of heavy episodic drinking among adolescents and adults, as appropriate, within the national context (5) Alcohol-related morbidity and mortality among adolescents and adults, as appropriate, within the national context
Physical inactivity	(3) A 10% relative reduction in prevalence of insufficient physical activity	(6) Prevalence of insufficiently physically active adolescents, defined as less than 60 minutes of moderate to vigorous intensity activity daily (7) Age-standardized prevalence of insufficiently physically active persons aged 18+ years (defined as less than 150 minutes of moderate-intensity activity per week, or equivalent)
Salt/sodium intake	(4) A 30% relative reduction in mean population intake of salt/sodium ³	(8) Age-standardized mean population intake of salt (sodium chloride) per day in grams in persons aged 18+ years
Tobacco use	(5) A 30% relative reduction in prevalence of current tobacco use in persons aged 15+ years	(9) Prevalence of current tobacco use among adolescents (10) Age-standardized prevalence of current tobacco use among persons aged 18+ years

Source: Appendix 2 of the draft Global Action Plan for the Prevention and Control of Noncommunicable Diseases (2013-2020)

¹Countries will select indicator(s) of harmful use as appropriate to national context and in line with WHO's *Global Strategy to Reduce the Harmful Use of Alcohol* and that may include prevalence of heavy episodic drinking, total alcohol per capita consumption, and alcohol-related morbidity and mortality, among others.

² In WHO's *Global Strategy to Reduce the Harmful Use of Alcohol*, the concept of the harmful use of alcohol encompasses the drinking that causes detrimental health and social consequences for the drinker, the people around the drinker and society at large, as well as the patterns of drinking that are associated with increased risk of adverse health outcomes.

³WHO's recommendation is less than 5 grams of salt or 2 grams of sodium per person per da

Annex 1

Biological risk factors		
Raised blood pressure	(6) A 25% relative reduction in the prevalence of raised blood pressure or contain the prevalence of raised blood pressure, according to national circumstances	(11) Age-standardized prevalence of raised blood pressure among persons aged 18+ years (defined as systolic blood pressure ≥ 140 mmHg and/or diastolic blood pressure ≥ 90 mmHg) and mean systolic blood pressure
Diabetes and obesity ⁴	(7) Halt the rise in diabetes and obesity	(12) Age-standardized prevalence of raised blood glucose/diabetes among persons aged 18+ years (defined as fasting plasma glucose concentration ≥ 7.0 mmol/l (126 mg/dl) or on medication for raised blood glucose) (13) Prevalence of overweight and obesity in adolescents (defined according to the WHO growth reference for school-aged children and adolescents, overweight—one standard deviation body mass index for age and sex, and obese—two standard deviations body mass index for age and sex) (14) Age-standardized prevalence of overweight and obesity in persons aged 18+ years (defined as body mass index ≥ 25 kg/m ² for overweight and body mass index ≥ 30 kg/m ² for obesity)
Additional indicators		(15) Age-standardized mean proportion of total energy intake from saturated fatty acids in persons aged 18+ years ⁵ (16) Age-standardized prevalence of persons (aged 18+ years) consuming less than five total servings (400 grams) of fruit and vegetables per day (17) Age-standardized prevalence of raised total cholesterol among persons aged 18+ years (defined as total cholesterol ≥ 5.0 mmol/l or 190 mg/dl); and mean total cholesterol concentration

⁴ Countries will select indicator(s) appropriate to national context.

⁵ Individual fatty acids within the broad classification of saturated fatty acids have unique biological properties and health effects that can have relevance in developing dietary recommendations.

National systems response		
Drug therapy to prevent heart attacks and strokes	(8) At least 50% of eligible people receive drug therapy and counselling (including glycaemic control) to prevent heart attacks and strokes	18) Proportion of eligible persons (defined as aged 40 years and older with a 10-year cardiovascular risk $\geq 30\%$, including those with existing cardiovascular disease) receiving drug therapy and counselling (including glycaemic control) to prevent heart attacks and strokes
Essential noncommunicable disease medicines and basic technologies to treat major noncommunicable diseases	(9) An 80% availability of the affordable basic technologies and essential medicines, including generics, required to treat major noncommunicable diseases in both public and private facilities	(19) Availability and affordability of quality, safe and efficacious essential noncommunicable disease medicines, including generics, and basic technologies in both public and private facilities
Additional indicators		<p>(20) Access to palliative care assessed by morphine equivalent consumption of strong opioid analgesics (excluding methadone) per death from cancer</p> <p>(21) Adoption of national policies that limit saturated fatty acids and virtually eliminate partially hydrogenated vegetable oils in the food supply, as appropriate, within the national context and national programmes</p> <p>(22) Availability, as appropriate, if cost-effective and affordable, of vaccines against human papillomavirus, according to national programmes and policies</p> <p>(23) Policies to reduce the impact on children of marketing of foods and non-alcoholic beverages high in saturated fats, trans fatty acids, free sugars, or salt</p> <p>(24) Vaccination coverage against hepatitis B virus monitored by number of third doses of Hep-B vaccine (HepB3) administered to infants</p> <p>(25) Proportion of women between the ages of 30–49 screened for cervical cancer at least once, or more often, and for lower or higher age groups according to national programmes or policies</p>

Very cost-effective¹ interventions ('best buys')² for prevention and control of NCD

Risk factor / Disease	Policy options / Interventions
Tobacco use	<ul style="list-style-type: none"> • Reduce affordability of tobacco products by increasing tobacco excise taxes • Create by law completely smoke-free environments in all indoor workplaces, public places and public transport • Warn people of the dangers of tobacco and tobacco smoke through effective health warnings and mass media campaigns • Ban all forms of tobacco advertising, promotion and sponsorship
Harmful use of alcohol	<ul style="list-style-type: none"> • Regulating commercial and public availability of alcohol • Restricting or banning alcohol advertising and promotions • Using pricing policies such as excise tax increases on alcoholic beverages
Unhealthy diet	<ul style="list-style-type: none"> • Reduce salt intake³ • Replace trans fats with unsaturated fats • Implement public awareness programmes on diet
Physical inactivity	<ul style="list-style-type: none"> • Implement public awareness programmes on physical activity
CVD and diabetes	<ul style="list-style-type: none"> • Drug therapy (including glycaemic control for diabetes mellitus and control of hypertension using a total risk approach) to individuals who have had a heart attack or stroke and to persons with high risk ($\geq 30\%$) of a fatal and nonfatal cardiovascular event in the next 10 years • Acetylsalicylic acid for acute myocardial infarction
Cancer	<ul style="list-style-type: none"> • Prevention of liver cancer through hepatitis B immunization • Prevention of cervical cancer through screening (visual inspection with acetic acid [VIA] (or Pap smear (cervical cytology), if very cost effective) linked with timely treatment of pre-cancerous lesions

Source: Appendix 3 of the draft Global Action Plan for the Prevention and Control of Noncommunicable Diseases (2013-2020)

¹ Very cost-effective, i.e., generate an extra year of healthy life for a cost that falls below the average annual income or gross domestic product per person

² In the global action plan, a detailed menu of options is provided under each objective along with WHO tools for achieving the voluntary global targets

³ And adjust the iodine content of iodized salt, when relevant.